TEXAS JUVENILE JUSTICE DEPARTMENT
TRANSFORMING YOUNG LIVES AND CREATING SAFER COMMUNITIES

Juvenile Justice Training Academy
Lesson Plan

Program:	Citation Source:
Juvenile Probation | Supervision Officer Basic Course	**TAC 37 Chapter 344**

Required by:
☐ **Texas Statute** ☒ **Texas Administrative Code** ☐ **Professional Development**

Course Title:
Recognizing and Supervising Juveniles with Mental Health Issues

Developed By:	Date:
Juvenile Probation RTO Team	**August 2014**
Revised By:	Date:
Delisha McLain, Curriculum Developer	**December 1, 2018**

PARAMETERS

Course Duration:	Minimum | Maximum Participants Recommended:
2.00 Hours	**5 - 50**
Instructional Setting:	Target Audience:
Classroom	**Juvenile Probation | Supervision Officers completing mandatory training.**

COURSE DESCRIPTION

This course examines prevalent mental health disorders juveniles are often diagnosed with while in the juvenile justice system. Supervision strategies for working with a juvenile with mental health needs will also be introduced.

APPROVALS

Technical Authority

Dr. Madeleine Byrne, Director of Treatment Date
State Programs and Facilities

Training Authority

Kristy Almager, Director Date
Juvenile Justice Training Academy

OBJECTIVES

At the conclusion of this course, participants will be able to:

1. Recognize the behaviors of prevalent mental health disorders experienced by juveniles in the juvenile justice system.
2. Examine appropriate supervision strategies for juveniles impacted by mental health issues.
3. Given a scenario, apply knowledge of mental health when considering actions for a juvenile with mental health needs.

INSTRUCTOR MATERIALS

1. TJJD Approved Lesson Plan, December 1, 2018
2. Copy of Current Participant Guide

PARTICIPANT MATERIALS

1. Participant Guide

REFERENCES

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ACKNOWLEDGEMENTS

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5. Ibid. Juvenile Justice Training Academy. JPO/JSO Basic Course. *Trauma Informed Care | A Focused Approach.* January 2018.

EQUIPMENT AND SUPPLIES

- ☒ Projector
- ☒ Laptop computer
- ☐ Chart Pad(s) or White Board
- ☐ Easel Stand (s)
- ☐ Marker(s)
- ☒ Screen
- ☐ Post-it Notes
- ☒ Laser Remote
- ☒ Batteries for Laser Remote
- ☐ Other

SCHEDULE

Introduction 10:00

Prevalent Juvenile Mental Health Disorders 40:00

Supervision Strategies 20:00

Mystery Mental Illness? 40:00

Final Thoughts 10:00

LEGEND

For Your Eyes Only
This is information for the Trainer only – it is facilitator guidance (i.e. Activity Instructions)

Speaker Notes
This will indicate information to be shared with participants

Action
This will direct facilitator when to do something (i.e. click to activate bullets, start media if necessary, chart participant responses)

Activity

This will indicate activity (small or large; individual or collaborative) before continuing on with presentation

Note: Unless otherwise indicated in the lesson plan and based on class size, the trainer has the discretion to use a designated group activity as an individual activity. The trainer shall process the activity, whether as designated or individually in an effort to maximize the learning environment for the participants.

IMPORTANT TRAINER INFORMATION

1. Prepare a **Parking Lot**. If a particular training course lends itself to potentially lengthy discussions that compromise training time, trainers are encouraged to prepare and use a Parking Lot in an effort to manage questions and time constraints efficiently. The Parking Lot is a piece of blank chart paper, titled **Parking Lot**. Paper is placed on a wall at the beginning of the training session, easily accessible to everyone.

   If the Parking Lot is used, place several pads of post-it® notes on participant tables for use during the training session and provide participants instructions on how a Parking Lot is used during training.

   The Parking Lot's purpose is to track questions asked by participants and allows trainer to either research an appropriate answer or respond to the question at the applicable time during the lesson plan. Prior to ending the training session, the trainer will review questions posted on the Parking Lot to determine if all have been answered or if additional research is needed. Trainer will either ask participants to confirm all posted questions have been answered satisfactorily or will acknowledge to participants the need to seek additional clarification from a subject matter expert (SME), the curriculum developer (CD), or other approved resource. A follow-up email should be provided to participants in the training session.

2. Cover all activities unless marked Optional.

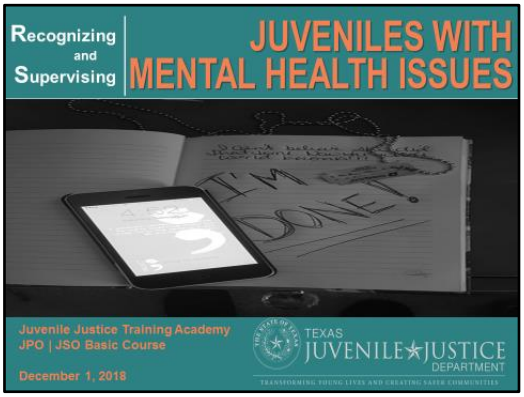
3. Time noted for an activity represents the entire activity process: introducing the activity, performing the activity steps, and debriefing the activity. During assigned activities, participants should be informed they have a "few" minutes to complete an activity instead of a set number of minutes (example: 10 minutes). This allows the trainer to shorten or lengthen time as needed.

4. During question and answer sessions or activities:
   a. Questions followed by the *(Elicit responses.)* statement – should be limited to 1 or 2 participant responses. These questions are used to gain audience acknowledgement and not meant to be a lengthy group discussion.

b. Questions followed by an italicized (suggested) response – are to be covered by the trainer or participants. If participant responses do not cover the complete italicized response, the trainer will provide participants with the remaining information. The responses provided are suggested best answers as approved by the Technical Authority. If participants suggest other responses, encourage them to explain their choices.

Disclaimer

The following curriculum was developed by the Texas Juvenile Justice Department. Approved curriculum is signed by both a Technical and Training Authority. The Certification exam is based on approved TJJD standardized curricula. TJJD is mindful some examples referenced in the lesson plan may not be applicable in particular counties. Deviations regarding the material are discouraged; however, enhancements explaining local policy and procedure without breaching the fidelity of the information are supported. If a participant requires additional information beyond the scope of this curriculum, refer the participant to his (or her) immediate supervisor.



Slide 1 - Introduction

Instructor's Corner: PG: 5

This slide appears with a picture. Click for the video to play, which takes a few seconds to begin, when it is mentioned in the LP.

Trainer Notes:

INTRODUCTION

(Welcome participants to the course and discuss the agenda including information on breaks, lunch time, and other pertinent information. If using the "Parking Lot," prior to class, prepare a chart to use later as noted in the Important Trainer Information section of the LP. Place Post-it® notes on the tables or next to the Parking Lot chart for participant use.)

(The Texas Juvenile Justice Department is mindful some examples referenced in the lesson plan may not be applicable in certain counties or facilities. Deviations from this TJJD approved curriculum are discouraged; however, enhancements explaining local policy and procedure without breaching fidelity of the information are acceptable.)

(Although not required, having a mental health professional in the training room while this course is being taught is recommended, in order to provide clarification and guidance on questions you may not able to answer.)

Welcome to the course on *Recognizing and Supervising Juveniles with Mental Health Issues*. It is estimated one in five adolescents are diagnosed with a severe mental

health disorder, while nearly three out of four juveniles involved in the juvenile justice system are diagnosed with one or more. Juveniles in our care have a higher prevalence of mental health issues than the general adolescent population, often attributed to the history of trauma they have endured. This trauma, such as violence, crime, and abuse may lead to post-traumatic stress disorder, or PTSD, one of the most prevalent mental health disorders with which juveniles are diagnosed.

The stigma surrounding mental health issues may make it difficult for some individuals to acknowledge their inability to cope, particularly teenagers, who in addition to potential mental health issues, are also trying to manage the challenges of normal adolescent development.

Let's take a moment to watch a video highlighting how one teen was ultimately able to cope with being in distress.

(Click to play video titled Mia's Story. Length is 4 minutes 7 seconds. Black screen remains after video ends.)

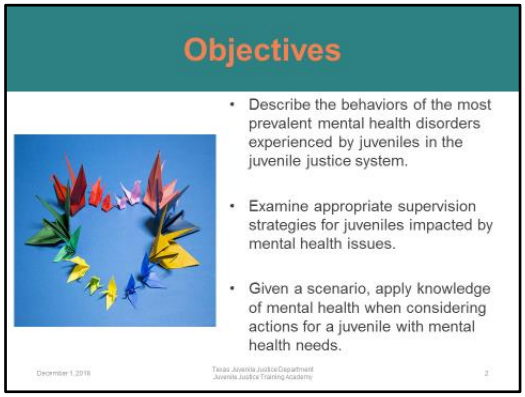
Q: What are your thoughts about the video? *(Elicit responses.)*

Mia had a supportive peer who helped her realize she may need to talk with someone about how she was feeling. As juvenile justice professionals, not only are we tasked with recognizing how mental health disorders manifest in juveniles, but we may be the one providing them support. Doing so may prevent juveniles from taking drastic measures when seeking relief from particularly strong emotions. Knowledge of mental health disorders, including how mental health issues impact

juvenile behavior, allows us to make positive, informed, and appropriate decisions for juveniles we supervise.

Today, we will talk about prevalent mental health disorders experienced by juveniles, how they are affected by those mental health disorders, and some strategies you may implement as you supervise them.

Let's review the objectives for the course today.



Slide 2 - Objectives

Instructor's Corner: PG: 5

This slide appears with a picture. Click for each of the objectives to appear as they are mentioned.

Trainer Notes:

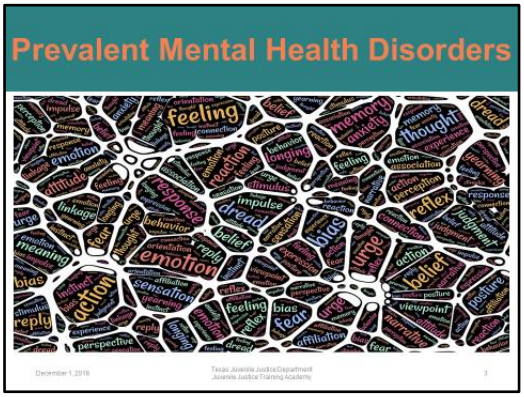
Objectives

(Click for each objective to appear as they are mentioned. Ask different participants to read each of the objectives.)

At the end of the course today, you should be able to:

1. Describe the behaviors of the most prevalent mental health disorders experienced by juveniles in the juvenile justice system.
2. Examine appropriate supervision strategies for juveniles impacted by mental health issues.
3. Given a scenario, apply knowledge of mental health when considering actions for a juvenile with mental health needs.

Q: What questions do you have before we get started? *(Answer questions, if any.)*



Slide 3 – Prevalent Mental Health Disorders

Instructor's Corner: PG: 5

Trainer Notes:

Prevalent Mental Health Disorders

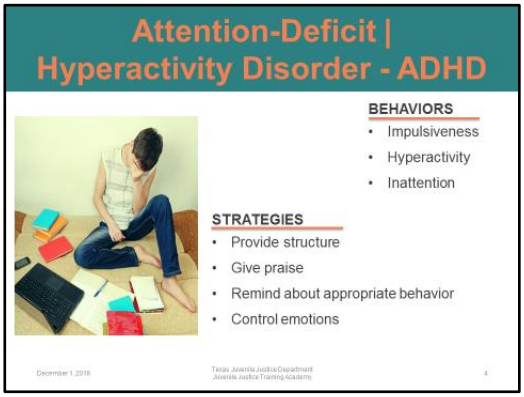
As a professional in the juvenile justice system, supervising juveniles coping with various mental health disorders is expected. Recognizing the most common disorders will help you make appropriate referrals for treatment and identify needed resources juveniles may need. You will work closely with mental health professionals, who use the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), to diagnose specific disorders. There are numerous disorders outlined in the DSM, some of which are most prevalent with juveniles in our care. Some of these mental health disorders include:

(Prevalent mental health disorders are listed in no particular order.)

- Attention–deficit | hyperactivity disorder – ADHD
- Autism spectrum disorder - ASD
- Conduct disorder
- Oppositional defiant disorder - ODD
- Bipolar disorder
- Disruptive mood dysregulation disorder - DMDD

- Major depressive disorder - MDD
- Post-traumatic stress disorder - PTSD

Let's take a moment to discuss these disorders along with specific interaction strategies for each.



Slide 4 – Attention-Deficit | Hyperactivity Disorder - ADHD

Instructor's Corner: PG: 5

This slide appears with a picture. Click for each of the behaviors and strategies to appear as they are mentioned in the LP.

Trainer Notes:

Attention-Deficit | Hyperactivity Disorder - ADHD

Working with juveniles in the juvenile justice system will quickly introduce you to attention-deficit | hyperactivity disorder (ADHD), which affects 18.3% of the juvenile population. It is one of the most common mental health disorders in young people and is characterized by impaired functioning in multiple settings, including home and school, as well as with relationships with peers. If untreated, ADHD may have long-term adverse effects well into adulthood.

(Click for each of the behaviors to appear as they are mentioned.)

Some behaviors of ADHD, which may appear over an extended period of time are:

- Impulsiveness
  - acting quickly without thinking
  - expressing reactions without thinking or restraint
  - blurting out inappropriate comments

  - ignoring possible consequences of bad behavior, instead focusing on short-term gratification

- Hyperactivity
  - inability to sit still
  - walking, running, or climbing on objects
  - talking over others

- Inattention
  - failing to focus on assigned tasks
  - daydreaming | appearing to be in another world
  - often sidetracked | distracted by nearby activities

As ADHD manifests through impulsivity and distraction, adults and especially teachers may be confused by juveniles who are able to spend all day playing video games but are unable to pay attention during class. This behavior occurs simply because juveniles diagnosed with ADHD often lose focus on activities which do not interest them.

Another common diagnosis in juveniles is attention deficit disorder (ADD), a subset of ADHD. With this disorder, inattention is more common than hyperactivity and juveniles diagnosed with this may have a hard time staying focused. They also get bored with a task after a few minutes so participating in activities they enjoy is easy, but having to focus on a new task or one they have no interest in is difficult. Other behaviors associated with ADD may include:

- Failing to pay attention to details; making careless mistakes

- Rarely following directions
- Losing or forgetting things such as pencils, books, and tools needed for a task
- Skipping from one uncompleted activity to another
- Forgetting daily activities
- Failing to listen when spoken to directly
- Being reluctant to engage in tasks requiring sustained mental effort

Q: How might these disorders create problems for juveniles? *(Elicit responses.)*

In addition to facing difficulties in school, juveniles diagnosed with ADHD or ADD may also struggle to follow their conditions of probation or goals outlined in a case plan. This may lead to frustration for the staff members supervising them.

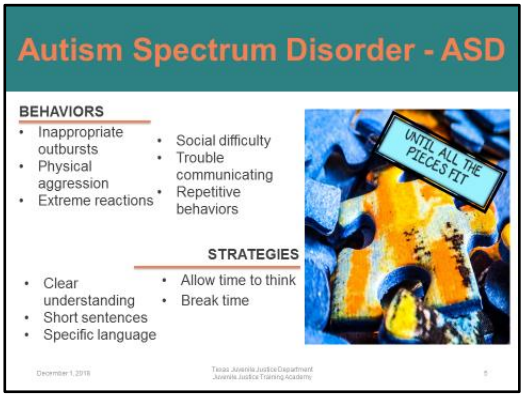
(Click for each strategy to appear as it is mentioned.)

There are some specific strategies you may use when interacting with juveniles diagnosed with ADHD. Although not an exhaustive list, these strategies aid with smoother interactions in any setting where you might work with juveniles diagnosed with ADHD, including at the office, in a secure setting, or at a juvenile's home. Consider the following:

- Provide structure | clear expectations.
- Give praise for acceptable behavior.
- Remind of appropriate behavior in social settings.
- Control your emotions during interactions.

Q: What questions do you have about ADHD? *(Answer questions, if any.)*

Let's move on to another common disorder, autism.



Slide 5 – Autism Spectrum Disorder - ASD

Instructor's Corner: PG: 6

This slide appears with a picture. Click for each of the behaviors and strategies to appear as they are mentioned in the LP.

Trainer Notes:

Autism Spectrum Disorder - ASD

Q: What is autism spectrum disorder? *(Elicit responses.)*

Autism, also known as autism spectrum disorder and which includes Asperger's syndrome and other developmental conditions, is a mental health disorder affecting a person's ability to socialize and communicate with others. The word "spectrum" is used when describing autism because of the wide range of abnormal behaviors which may be manifested with it. Using a spectrum allows mental health professionals to interpret how mild or severe a person's impairment is based upon their symptoms.

The symptoms of autism may manifest at any time. Parents or caregivers are usually the first to notice these unusual behaviors. For instance, a baby may seem "different" from the time of birth, appearing to be unresponsive to people or focusing intently on one thing for long periods of time. On the other hand, behaviors may suddenly appear in a normally developing child. Usually

affectionate and talkative, a child may unexpectedly become silent, withdrawn, self-abusive, or indifferent to social cues.

(Click for each of the behaviors to appear as they are mentioned.)

Other behaviors associated with autism may include:

- Inappropriate outbursts
- Physical aggression
- Unusual responses to sensory experiences (for example, extreme reactions to certain sounds or the way objects look)
- Difficulty in social interactions
- Trouble with verbal | non-verbal communication
- Repetitive behaviors or interests

Juveniles with ASD may be slow to interpret what others are thinking and feeling in addition to having trouble with reading social cues like a smile, wink, or frown. This may become problematic during school when interacting with other students and teachers, especially when behaviors like crying and verbal outbursts disturb the classroom environment. Juveniles with ASD may also be physically aggressive and break things, attack others, or hurt themselves.

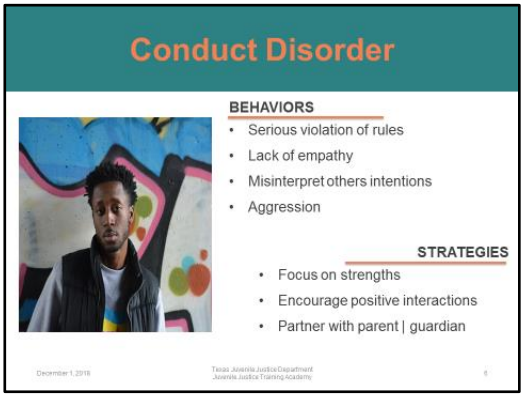
(Click for each strategy to appear as it is mentioned.)

When interacting with juveniles diagnosed with autism, consider the following strategies:

- Provide a clear understanding of what you expect.
- Use short sentences and clear language.
- Ask specific questions to avoid misunderstandings.
- Allow a juvenile time to think before expecting a response.
- Grant time for frequent breaks, especially if housed in a secure setting.

Q: What questions do you have about autism? *(Answer questions, if any.)*

Let's move on to another common disorder with juveniles, conduct disorder.



Slide 6 – Conduct Disorder

Instructor's Corner: PG: 6

This slide appears with a picture. Click for each of the behaviors and strategies to appear as they are mentioned in the LP.

Trainer Notes:

Conduct Disorder

Conduct disorder may be characterized by violent reactions and a disregard for other people. Juveniles with this disorder are often labeled juvenile delinquents and often dismissed because of their "bad" behavior. They not only find great difficulty in following rules, but also have trouble displaying socially acceptable behavior, especially in school environments.

(Click for each of the behaviors to appear as they are mentioned.)

Additional behaviors associated with conduct disorder may include:

- Committing serious violation of rules (for example, theft, vandalism, and arson)
- Lacking empathy and conscience; potentially leading to deceitfulness, lying, or stealing
- Misinterpreting the intentions of others

- Behaving aggressively towards people and animals (for examples, bullying, picking fights, pushing, hitting others, or animal cruelty)

To be diagnosed with conduct disorder, juveniles must exhibit these behaviors consistently over time. It is possible a juvenile diagnosed with conduct disorder may develop antisocial personality disorder in adulthood, so a diagnosis of conduct disorder must receive treatment as early as possible.

(Click for each strategy to appear as it is mentioned.)

Some specific strategies you may consider in your approach with juveniles diagnosed with conduct disorder:

- Focus on strengths after determining specific problem areas.
- Encourage positive social interactions with others.
- Partner with parent | guardian to focus on and praise positive behavior at home.

Q: What questions do you have about conduct disorder? *(Answer questions, if any.)*

This disorder is similar to oppositional defiant disorder, another common mental health disorder affecting some juveniles.

Slide 7 – Oppositional Defiant Disorder - ODD

Instructor's Corner: PG: 6

This slide appears with a picture. Click for behaviors and strategies to appear as they are mentioned in the LP.

Trainer Notes:

Oppositional Defiant Disorder

Oppositional defiant disorder (ODD) is characterized by anger, irritability, defiance toward authority figures, and vindictiveness. ODD behaviors typically occur in the home, but in more severe cases, may happen at school or other environments.

(Click for each of the behaviors to appear as they are mentioned.)

To be diagnosed with ODD, at least four of the following eight behaviors must be present at least once a week for six months, including:

- Loss of temper
- Argumentative
- Refusing to comply with requests or rules
- Deliberately annoying others
- Blaming others for mistakes or misbehavior
- Easily annoyed or irritated by others
- Displaying anger and resentfulness

- Being spiteful or vindictive

Juveniles diagnosed with ODD may also have a difficult time with impulse control. When acting out, they typically have intent and purpose behind their behavior and feel no regret over their actions. This is different from conduct disorder, where juveniles often misinterpret the intentions of others and may react with aggression.

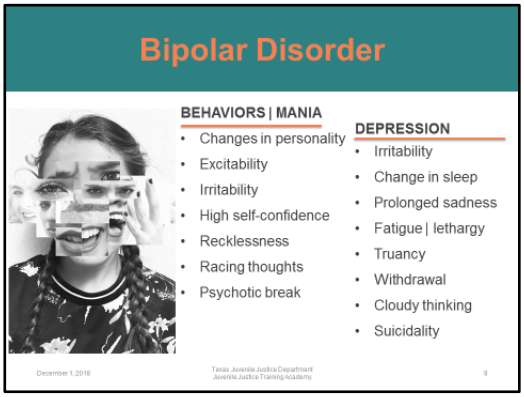
(Click for each strategy to appear as it is mentioned.)

When interacting with juveniles diagnosed with ODD, consider the following strategies:

- Respond to unacceptable behavior without anger.
- Be clear | consistent with expectations.
- Do not take things personally, particularly when a juvenile is exceptionally challenging.
- Issue appropriate consequences for negative behavior.
- No excessive punishment, particularly when you are angry.

Q: What questions do you have about ODD? *(Answer questions, if any.)*

Next, let's talk about bipolar disorder.



Slide 8, 9 – Bipolar Disorder

Instructor's Corner: PG: 7

This slide appears with a picture. Click for the behaviors and strategies to appear as they are mentioned in the LP.

Trainer Notes:

Bipolar Disorder

Bipolar disorder is a serious medical condition causing shifts in a person's mood, energy, and ability to function. Different from the normal ups and downs most people experience, behaviors of bipolar disorder are typically considered severe. The disorder is characterized by dramatic mood swings, from feeling overly high, happy, and excited to irritable, sad, and hopeless, with bouts of steadiness in between. These highs, called mania and lows, called depression typically occur on a spectrum and vary from individual to individual.

Mania, or manic episodes, are distinguished by elevated moods which occur most of the day, nearly every day, for a week or longer. These episodes range from mild to severe.

(Click for each of the behaviors to appear as they are mentioned.)

Some behaviors associated with mania include:

- Drastic changes in personality
- Excitability
- Irritability
- Inflated self-confidence
- Recklessness
- Racing thoughts
- Psychotic breaks from reality

On the other end of the spectrum is depression, ranging from severe, moderate, or low, often called "the blues" if it goes on for long periods.

(Click for each of the behaviors to appear as they are mentioned.)

Some behaviors associated with depression may include:

- Irritable mood
- Decreased ǀ increased need for sleep
- Prolonged sadness
- Fatigue ǀ lethargy
- Truancy
- Withdrawal from friends and family
- Cloudy ǀ indecisive thinking
- Suicidality

(Click for each of the behaviors to appear as they are mentioned.)

Some individuals may experience both mania and depression simultaneously, called mixed bipolar state. Here, a person may feel sad and hopeless, while in a highly energized state.

Other behaviors associated with a mixed bipolar state may include:

- Agitation
- Trouble sleeping
- Changes in appetite
- Psychosis
- Suicidality

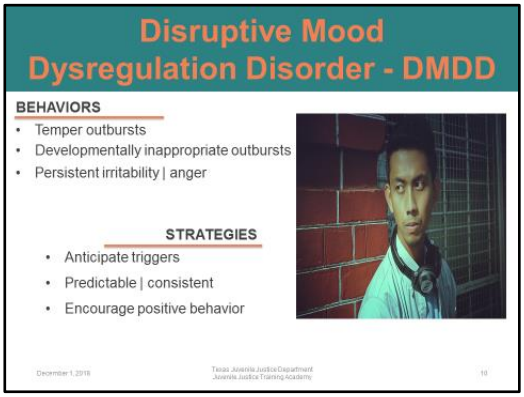
(Click for each strategy to appear as it is mentioned.)

Consider the following strategies when interacting with juveniles diagnosed with bipolar disorder:

- Verify medication is ordered and taken as prescribed.
- Be patient with cycles of behavior.
- Identify activities the juvenile enjoys | refer to resources in community.
- Encourage individual and family counseling.

Q: What questions do you have about bipolar disorder? *(Answer questions, if any.)*

Many juveniles have been diagnosed with bipolar disorder, which has resulted in its over diagnosis. To address this, a new disorder, disruptive mood dysregulation disorder was added to the DSM-5. Let's discuss this new disorder now.



Slide 10 - Disruptive Mood Dysregulation Disorder - DMDD

Instructor's Corner: PG: 7

This slide appears with a picture. Click for the behaviors and strategies to appear as they are mentioned in the LP.

Trainer Notes:

Disruptive Mood Dysregulation Disorder - DMDD

Disruptive mood dysregulation disorder (DMDD) is a childhood condition, characterized by chronic, severe irritability in between frequent aggressive outbursts. Unlike bipolar disorder, individuals with DMDD do not experience the highs and lows of mania and depression, nor do they go on to develop an adult form of the disorder. This disorder is not diagnosed before age 6 or after age 18; with behaviors typically beginning around age 10. Without treatment, the likelihood of developing depression and anxiety disorders as an adult increases.

(Click for each of the behaviors to appear as they are mentioned.)

Behaviors of DMDD may include:

- Severe recurrent temper tantrums | verbal or behavioral
- Developmentally inappropriate outbursts
- Persistent irritability or anger between outbursts

To be diagnosed with DMDD, tantrums and an irritable mood in a juvenile must:

- Have lasted for at least one year
- Occur at least three times a week
- Must be apparent by age 10

With persistent irritability and anger being the primary behaviors of DMDD, this diagnosis may cause a strain on relationships juveniles have with parents, peers, educational staff, or other positions of authority. Unlike ODD, juveniles with DMDD act out based on their feelings of irritability, typically with no intent behind their actions.

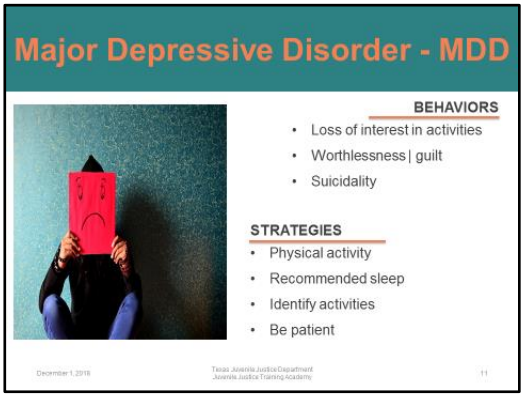
(Click for each strategy to appear as it is mentioned.)

Some strategies you may consider when interacting with juveniles diagnosed with DMDD:

- Anticipate events which may trigger an outburst.
- Be predictable | consistent.
- Encourage appropriate behavior.

Q: What questions do you have about DMDD? *(Answer questions, if any.)*

Now let's talk about depression, another common mental disorder prevalent in juveniles.



Slide 11 – Major Depressive Disorder - MDD

Instructor's Corner: PG: 7

This slide appears with a picture. Click for the behaviors and strategies to appear as they are mentioned in the LP.

Trainer Notes:

Major Depressive Disorder - MDD

Major depressive disorder is a serious medical illness, which is disabling and prevents normal day-to-day functioning. It is more than just being "down in the dumps" or feeling "blue" for a few days. It is actually feeling sad, low, and hopeless for weeks at a time. Only in the past two decades has depression in juveniles been taken seriously and not considered something they make up in their head. A juvenile experiencing depression may pretend to be sick, refuse to go to or have trouble in school, sulk, display a negative attitude, or feel misunderstood. Unlike bipolar disorder, characterized by bouts of depression, a diagnosis of major depression does not include episodes of mania.

(Click for each of the behaviors to appear as they are mentioned.)

Symptoms for MDD exist on a spectrum, ranging from mild, potentially lasting for long periods to major depression. Along with the bipolar disorder behaviors associated with depression mentioned earlier, a few others related to MDD may include:

- Loss of interest in pleasurable activities
- Feelings of worthlessness | guilt
- Recurrent thoughts of death | suicidal ideation

Juveniles with MDD may also experience a slowing of speech and body movement and sluggish thinking, which directly impacts school performance, decision making, and relationships. Another possible symptom of MDD is anxiety, or intense feelings of fear or worry blown out of proportion in relation to what is actually happening. Anxiety coupled with depression may lead to feelings of inadequacy and self-medicating, often with illegal substances.

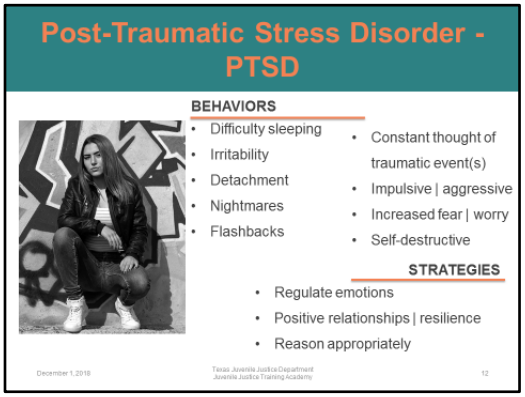
(Click for each strategy to appear as it is mentioned.)

When interacting with juveniles diagnosed with MDD, consider the following strategies:

- Encourage participation in physical activity, to potentially decrease symptoms.
- Verify the recommended amount of sleep is being received by collaborating with parents | guardian.
- Identify relaxing activities.
- Be patient and mindful of depressed or anxious feelings.

Q: What questions do you have about MDD? *(Answer questions, if any.)*

Juveniles in the juvenile justice system have most likely experienced traumatic events, or adverse childhood experiences, in their lives, thus we are going to talk about a mental health disorder they may be diagnosed with as a result of these traumas, post-traumatic stress disorder (PTSD).



Slide 12 – Post-Traumatic Stress Disorder - PTSD

Instructor's Corner: PG: 8

This slide appears with a picture. Click for the behaviors and strategies to appear as they are mentioned in the LP.

Trainer Notes:

Post-Traumatic Stress Disorder - PTSD

Post-Traumatic Stress Disorder (PTSD) is a condition brought on by exposure to stressful, traumatic events. The more traumas a juvenile has, the higher the likelihood they may experience physical and mental health problems in adulthood. The disorder is more likely to manifest based on certain risk factors, including:

- Severity of the trauma
- Prior exposure to trauma
- Parental response to the trauma

(Click for each of the behaviors to appear as they are mentioned.)

Examples of traumatic events include experiencing sexual or physical abuse, witnessing a violent episode, coping with the suicide of a close friend or family member, or incarceration of a parent. Juveniles with PTSD may not heal quickly after these events and often develop behaviors such as:

- Difficulty sleeping
- Irritability
- Detachment
- Nightmares
- Flashbacks
- Constant thoughts about traumatic events
- Impulsiveness | aggressiveness
- Increased fear | worry | guilt
- Self-destructiveness

(Click for each strategy to appear as it is mentioned.)

Some strategies you may consider when interacting with juveniles diagnosed with PTSD:

- Teach skills to regulate emotions.
- Encourage development of positive relationships and resilience.
- Introduce ways to reason appropriately.

Q: What questions do you have about PTSD? *(Answer questions, if any.)*

You will learn more about this disorder in the *Trauma-Informed Care* course, but for now, let's put your knowledge of these prevalent mental health disorders into practice with an activity.

Slide 13 – Activity | Mental Health Quest

Instructor's Corner: PG: 8

Trainer Notes:

For Your Eyes Only – Activity | Mental Health Quest

1. Individually, have participants read the quotes, choose the mental health disorder it best describes, and check the appropriate box.
2. Upon completion, have participants share their answers in the large group.
3. Encourage participants to correct their answers, if necessary, as they are discussed.

Activity Point: To provide participants with an opportunity to recognize mental health disorders, learned in this course, juveniles may be diagnosed with.

Activity | Mental Health Quest — Time: 15 Minutes

In your participant guide, turn to the activity titled *Mental Health Quest.* Individually, read the quote, choose which mental health disorder it best describes, and write the corresponding letter next to it. Each quote will have only one answer. Once finished, we will discuss the answers as a large group.

Debrief

(Have various participants read each quote and indicate what letter and corresponding mental health disorder they chose. Allow time for brief discussions about the responses, provide the correct answers, and additional information as shown below. Encourage participants to correct any mistakes they may have then move on to the next quote.)

| Activity Answers

1. "I get in trouble in school because I can't sit still, I talk way too fast, and I feel like I am just so full of energy. Last week though, I was so down, I didn't want to talk to anyone and actually was hospitalized because I tried to kill myself." | **Bipolar disorder**
   Bipolar disorder is characterized by episodes of mania and depression. A juvenile may experience these episodes for one to several days, from mild to severe.

2. "I frequently hit my little sister and scream at her when she doesn't listen. Yesterday, I threw my phone against the wall. Why? Because the battery died." | **Disruptive mood dysregulation disorder**
   DMDD is characterized by frequent aggressive outbursts and developmentally inappropriate outbursts.

3. "When we are walking to our housing unit in juvenile detention, the sound of the big metal doors slamming is just so loud. I feel like the noise is in my head." | **Autism disorder**

Juveniles diagnosed with autism often experience unusual responses to sensory experiences and it may manifest as mild, often called Asperger's disorder to severe.

4. "I just can't shake this feeling I have. I want my friends to invite me out, but I don't feel like getting dressed to go with them. I am just so down and out." | **Major depressive disorder**
   Juveniles experiencing depression may also often have trouble sleeping, often feel worthless, and may have suicidal thoughts.

5. "I can't stand my teacher. Nothing he says is true and I often argue with him, so I can have the last word. I also hate Cassidy; she has her own car and doesn't deserve one." | **Oppositional defiant disorder**
   Juveniles diagnosed with ODD are often spiteful or vindictive and are usually defiant with people around them.

6. "I can't get the thought of him on top of me out of my head. I am terrified being alone at home by myself." | **PTSD**
   PTSD is characterized by constant thoughts of traumatic events. A juvenile diagnosed with PTSD may have recurring dreams and engage in self-destructive behavior.

7. "I cannot focus in class; it is just difficult. I try to listen, but it's like I can't hear the words." | **ADHD**
   ADHD is characterized by impulsiveness, hyperactivity, and a lack of focus, however, it should not be confused with normal adolescent development and behavior. This is why an assessment by a mental health professional is needed with regard to this and all of the other disorders we have discussed today.

8. "I set the bathroom trash can on fire the other day and could care less what happens to me." | **Conduct Disorder**

   Juveniles are often labeled juvenile delinquents when diagnosed with this disorder and are thought of as "bad." If not treated, this disorder may lead to adult antisocial personality disorder, so the earlier the treatment begins the better.

Q: What questions do you have about this activity or the disorders we have covered? *(Answer questions, if any.)*

When interacting with juveniles or making determinations about them, oftentimes, these disorders occur simultaneously, causing increased behavioral symptoms. For example, a juvenile diagnosed with PTSD may experience changes in sleep and appetite, which may lead to a diagnosis of MDD.

Before we move on to the next section of the course, let's talk about the effect social media has on juvenile mental health.

Slide 14 – Social Media

Instructor's Corner: PG: 9

This slide appears with a picture. Click for the effects and video to appear as they are mentioned in the LP.

Trainer Notes:

Social Media

Q: How does social media affect the way juveniles feel about themselves? *(Elicit responses.)*

Social media has a profound impact on juveniles' feelings of self-worth and confidence because the ways in which interactions are interpreted have shifted. For instance, a sense of identity, highly important to juveniles, is often equated to the number of "likes" received online, which is often directly correlated to how juveniles feel about themselves. Many juveniles believe receiving comments, likes, favorites, reblogs, or retweets is a reflection of their personal identity so when this type of attention is not received, it may trigger increased anxiety, depression, and often worsens feelings of unworthiness.

Let's take a moment to watch a video about how social media impacts juveniles.

(Click to play video titled Dr. Michael Nerney and Social Media. Length is 2 minutes 6 seconds.)

Q: What are your thoughts about the video? *(Elicit responses.)*

(Click for each of the effects to appear as they are mentioned.)

Other negative effects of social media include:

- Cyberbullying

  Defined as the intent to use comments and likes to make a juvenile feel worse about themselves. Bullying online may lead to suicidal ideation or suicide.

- Online predators

  Social media sites are often hubs for sexual predators. These abusers take advantage of troubled juveniles, which may lead to dangerous consequences (for example, human trafficking, substance use, or death).

- Negative body image

  When juveniles' compare their outward appearance with others, it often increases feelings of inadequacy and depression.

- Fear of missing out (FOMO)

  Juveniles fear they are missing out on something everyone else seems to know about or is doing. They may feel unpopular or disliked if they are not

participating in the same activities as their peers, which may lead to psychological distress, depression, and increased anxiety.

These negative side effects of social media make some of the mental health disorders we talked about worsen, potentially leading to serious issues such as suicidal ideation, low self-esteem, and substance abuse. Taking a periodic break from social media may be beneficial to those who have been diagnosed with a mental health disorder.

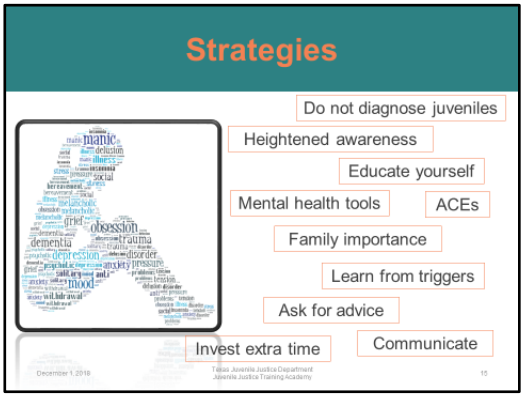
Q: What are some ways to limit a juvenile's exposure to negativity on social media? *(Elicit responses.)*

Although we might not control the amount of time a juvenile spends on their phone while they are being supervised, we must encourage parents to:

- Limit the amount of time on social media.
- Set specific time limits on all electronic devices.
- Block inappropriate sites.
- Monitor internet use.
- Repeatedly check for accounts on unsuitable websites or applications.

Q: What questions do you have about social media and juveniles? *(Answer questions, if any.)*

Next, let's discuss some general strategies you may implement when interacting with juveniles.



Slide 15 – Strategies

Instructor's Corner: PG: 9

This slide appears with a picture. Click for strategies to appear as they are mentioned in the LP.

Trainer Notes:

STRATEGIES

In the juvenile justice system, three out of four juveniles are diagnosed with a mental health disorder, which makes it likely several juveniles under your supervision have a mental health diagnosis. Recognizing behaviors associated with mental health disorders allows you to make sound referrals for treatment and will guide interactions with juveniles you manage.

(Click for strategies to appear as they are mentioned.)

You must also be aware of mental health resources at your disposal and identify ways to increase your problem-solving ability, save you time, and create positive relationships with families. Some strategies to consider:

- Do not diagnose juveniles

  Juveniles must only be evaluated and diagnosed by a mental health professional. Your job is to gather relevant information from reputable sources and manage juveniles based on what you find. You may believe a

juvenile has a mental health illness and if so, you have a moral obligation to refer the juvenile for an evaluation, if he or she has not been evaluated already. You will learn more about your professional and moral duties in the *Understanding Professional Liability* course.

- Maintain heightened awareness

  Be aware of what each juvenile under your supervision is diagnosed with and whether they are taking medication. This information will be needed for any necessary mental health and other referrals as well as during court proceedings if necessary. If a juvenile is housed at juvenile detention, knowing their diagnosis and prescribed medication is critical; it allows you to anticipate possible triggers and keeps all juveniles safe, particularly if one needs to be moved from a housing unit because of behavioral issues or situations related to medication.

- Educate yourself

  Being knowledgeable about and having the ability to recognize behaviors of prevalent mental health disorders helps you know what to expect from and how to interact with a particular juvenile on supervision. Chronological notes and other case file documents are filled with vital information concerning not only a mental health diagnosis of a juvenile, but also behaviors associated with it. Review these notes and keep detailed chronologicals for all juveniles on supervision.

  These are not the only documents which contain valuable information. Psychological reports are filled with information about mental health diagnoses. It outlines a juveniles' specific diagnosis, includes pertinent

background information about him (or her), and includes recommendations for treatment. Ask if the family has access to a psychological report and obtain a copy for your records. If you do not have access to a psychological report or are not responsible for case management, collaborate with other professionals working with a juvenile in order to gather relevant details about particular behavior. Review files kept in juvenile detention or debrief reports provided after a shift. These reports are critical when determining problem areas in a housing unit.

- Rely on implemented mental health tools

  The Texas Administrative Code mandates a mental health assessment must be administered for all juveniles who are referred to the juvenile probation department. The Massachusetts Youth Screening Instrument-Second Version (MAYSI) is a tool often used by juvenile probation departments and identifies potential concerns in key mental health areas. The Positive Achievement Change Tool (PACT) is also an assessment some departments use, which identifies risks and needs, and will highlight whether mental health is an issue with juveniles. Be aware of what assessment tools your department uses and make decisions based on the information.

- Consider ACEs of juveniles

  Be mindful of the number of adverse childhood experiences (ACEs) or traumatic events a juvenile may have. High ACEs coupled with a mental health issue may delay progress for a juvenile during supervision. This must be a factor you contemplate when setting appropriate goals and accessing their priority. You will learn more about setting reasonable goals in the

Customized Case Design course and about ACEs in the *Trauma-Informed Care* course.

- Learn from triggers

  Be mindful of certain actions or communication styles which may potentially affect a juvenile's overall mood. This will help avoid situations which may escalate. You can never be sure if a certain look, phrase, or reaction may cause a juvenile to react. Always remember to observe juveniles' behavior and decrease triggering actions as much as you can.

- Consider parents | guardians | family members as resources

  Parents and guardians likely began handling a juvenile's mental health diagnosis long before he (or she) was involved in the juvenile justice system. Family members and caretakers will have knowledge about:

  - coping techniques
  - possible trigger points
  - prescribed medications

  Be sure all pertinent information is recorded in juvenile case files, court reports, and referrals to counseling services. In addition, if a juvenile is housed at juvenile detention or other facility, collaborate with mental health professionals, who have likely met with parents or guardians, if unusual behavior is observed or some behavioral strategies are needed.

- Ask for advice

  When supervising juveniles, always seek more knowledge by conferring with more tenured coworkers or mental health professionals. If you have a difficult

time managing certain juveniles, solicit guidance from others who may have more experience with certain mental health disorders.

- Communicate with respect

  Actively listen to juveniles, providing your undivided attention. Avoid multitasking when interacting with them, as it may be perceived as a disinterest in or disregard for them and their feelings. Be aware of your nonverbal communication; present an open posture and maintain eye contact. Finally, show you understand what a juvenile is saying by repeating back what you have heard.

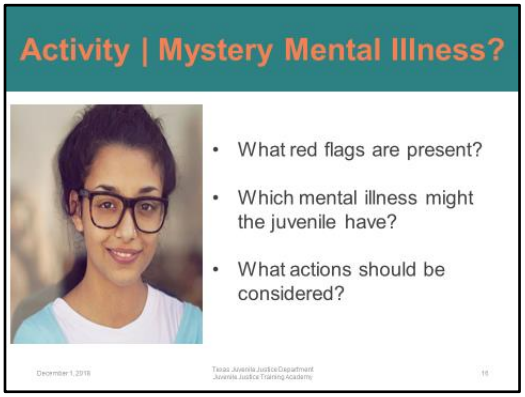
- Invest extra time

  If necessary, spend extra time with a juvenile and his (or her) family. Do not rush interactions, particularly if a juvenile is having a difficult time expressing him (or herself). Seeing things from their perspective conveys empathy and respect. Spending a few extra minutes with them may lead to the discovery of new, applicable information.

These strategies may be applied to any juvenile, regardless of whether they are diagnosed with a mental health disorder. Do not make assumptions about a juvenile's behavior or label a juvenile with a disorder if they are not formally diagnosed with one. Sometimes, behavior a juvenile displays is merely the result of normal adolescent development.

Q: What questions do you have about these strategies? *(Answer questions, if any.)*

Let's put your knowledge to the test by completing an activity.



Slide 16 – Activity | Mystery Mental Illness?

Instructor's Corner: PG: 10

Trainer Notes:

For Your Eyes Only – Activity | Mystery Mental Illness?

1. In groups of 2-4, have participants choose a spokesperson, then read each scenario and answer the questions in the participant guide.
2. Inform participants these scenarios are *not* designed for them to diagnose juveniles, merely to explore situations they may encounter while managing juveniles. A diagnosis must only be rendered by a licensed mental health professional.
3. Once finished, have spokesperson share the small group answers to the large group.

Activity Point: To provide participants an opportunity to apply what they know about mental health disorders, learned in this course, to hypothetical scenarios involving juveniles on supervision. There may be multiple correct answers for each scenario, not all identified in the debrief section of this LP.

Activity | Mystery Mental Illness? Time: 40 Minutes

In your participant guide, turn to the activity titled *Mystery Mental Illness?* In small groups, chose a spokesperson, then read each scenario and answer the questions in the space provided. Once finished, the spokesperson will share the small group answers with the large group.

Debrief

(Ask for varying volunteer spokespersons to share their small group answers with the large group.)

Scenario 1 | Billy

Billy was recently placed under your supervision. At the initial meeting, you interview Billy and his parents separately. They report Billy has been displaying some aggressive behavior with them, most recently after a basketball game he played in. When Billy was asked about a particular play, he charged at his parents and tried to punch his father in the face. After he calmed down a bit, Billy said one of his teammates disrespected him, which upset him. He later saw some comments online saying he was the reason they lost the game, which several people "liked". This behavior has happened before, according to Billy's parents, usually after Billy returns home from school. It was reported Billy has always had a short fuse with others, but it has since escalated. Billy usually locks his room door, but his mom recently went in after he left for school and found a knife under his pillow.

Q: What red flags are present with Billy?

A: Billy's red flags include:

- *Aggressive behavior, specifically him charging at his parents and trying to punch his father in the face*
- *Prior aggressive behavior*
- *Knife under Billy's bed*

Q: Which mental illness might Billy have?

A: Based on Billy's aggressive responses to certain triggers, he may have oppositional defiant disorder (ODD) or disruptive mood dysregulation disorder (DMDD). This may also be a case of bullying; however, a mental health evaluation is warranted because of the history of aggressive behavior.

Q: What actions should be considered for Billy?

A: Some actions for Billy may include:

- *A referral to mental health professional for evaluation.*
- *Set case plan goals related to mental health treatment and family counseling.*
- *Remind parents to call law enforcement if Billy's behavior is uncontrollable or they feel they or someone else are in danger.*
- *Contact the school-this may only be a case of bullying, however, the school should implement a plan to keep Billy and other students safe, if necessary.*
- *Address mental health issues each time the family reports.*

Scenario 2 | Cindy

Cindy, a juvenile on your caseload appears in court looking more withdrawn than she was when you talked with her last week. She does not acknowledge you and goes to stand as far away from everyone in the courtroom as possible. Cindy's

mother tells you her daughter has been lazy, tired, and has not completed any of her chores this week. Her mother also noted Cindy has only wanted to sleep and when she did go to school, she was caught sleeping during class. This is unusual because last week, Cindy was helpful, energetic, talked non-stop, and even helped her younger brother with his homework. Over the last week, Cindy was told several times to get off of the phone and get some sleep, but Cindy refused and said she would rather talk to her friends. Cindy's mom is tired of her daughter's behavior and believes she is simply being a typical teenager.

Q: What red flags are present with Cindy?

A: Cindy's red flags include:

- *An extreme shift in behavior, from non-stop talking and excitability to extreme sleepiness and wanting to be alone*
- *A failure to complete chores when she had so before*
- *Truancy*

Q: What mental illness might Cindy have?

A: Based on Cindy's extreme behavioral shifts, she may be suffering from bipolar disorder.

Q: What actions should be considered for Cindy?

A: Some actions for Cindy may include:

- *A referral to mental health professional for evaluation.*
- *Set case plan goals related to mental health treatment and family counseling.*
- *Educate Cindy's mother on mental health issues in teens. Explain until an evaluation is completed on Cindy, her behavior should not be blamed solely on adolescent development. Identify resources Cindy's mother may access.*

- *Contact the school and consult with Cindy's teachers and counselors. There may be other problems at school, which no one is aware of.*
- *Address mental health issues each time the family reports.*

Scenario 3 | Pam

Pam has been hospitalized on three occasions for suicide attempts, has exhibited oppositional behaviors in the past, and was recently uncooperative while placed on a Crisis Stabilization Unit. After a week, Pam was discharged from crisis stabilization and returned home with her father and siblings. Pam quickly became aggressive with her family and was again taken into custody and taken to juvenile detention. While in the gym, Pam talks to you and begins crying. She said doesn't want to go home because he uncle has been sexually abusing her. Pam said she has not told anyone about this.

Q: What red flags are present with Pam?

A: Pam's red flags include:

- *Previous suicide attempts*
- *Aggressive behavior with her family while at home*
- *Outcry of sexual abuse*

Q: Which mental illness might Pam have?

A: Based on Pam's behavior, it may be assumed she is suffering from a mental disorder such as oppositional defiant disorder (ODD), disruptive mood dysregulation disorder (DMDD) or post-traumatic stress disorder (PTSD). In this case, Pam's behavior was being used as a coping mechanism, concealing the fact she was being sexually abused.

Q: What actions should be considered for Pam?

A: Some actions for Pam may include:

- *A referral to mental health professional in juvenile detention to make sure Pam is stable.*
- *Monitor Pam until she is seen by mental health professional.*
- *As first responder, follow local procedures regarding how to report an incident of abuse, neglect, or exploitation. You have a moral and legal obligation to report this information to law enforcement, the Texas Juvenile Justice Department (TJJD), and the parent.*

Scenario 4 | Jay

Jay is a 13-year-old boy on probation for assaulting his mother. He is currently in juvenile detention for allegedly assaulting her a second time. You speak with his mother, who says she is concerned about Jay's aggressive conduct with her and his behavior at school. His first report card reveals he is failing most of his classes and his teacher says he acts up in class, is disobedient, disrespectful, doesn't sit still, and fights with other students.

Jay's mother moved the family to the United States from Jamaica two years ago for a chance at a better life. Jay primarily lived with his grandmother in Jamaica and wants to go back to live with her.

Q: What red flags are present with Jay?

A: Jay's red flags include:

- *Previous assaultive history against mother*
- *Poor behavior in school*

- *Aggressive behavior with his mother and other students*

Q: Which mental illness might Jay have?

A: Based on Jay's behavior, he may be suffer from conduct disorder, attention-deficit | hyperactivity disorder (ADHD), or disruptive mood dysregulation disorder (DMDD). In this case, Jay's behavior may be because he is having a hard time adjusting to a new environment and is yearning to return home. Only a complete mental health assessment will determine this.

Q: What actions should be considered for Jay?

A: Some actions for Jay may include:

- *A referral to mental health professional for an assessment.*
- *Set case plan goals related to mental health treatment and family counseling.*
- *A referral for mentorship to help Jay adjust.*
- *Addressing mental health issues each time the family reports.*

Scenario 5 | Laura

Laura is currently in juvenile detention for a drug charge. This is her third time being arrested in the last few months. Her file is full of violations. Laura is a constant disruption in the housing unit, starting altercations with other girls and being challenging with educational staff. Laura blames everyone for her behavior and said she doesn't belong in detention. She says she will do better if her JPO recommends she go home.

Q: What red flags are present with Laura?

A: Laura's red flags include:

- *Previous arrest record*
- *Defiant behavior*
- *Blaming others for her behavior*

Q: Which mental illness might Laura have?

A: Based on Laura's behavior, she may be suffering from disruptive mood dysregulation disorder (DMDD), but it is hard to determine with such little information. In this case, Laura may be acting out simply because she wants to go home. More information is needed to make a determination.

Q: What actions should be considered for Laura?

A: Some actions for Laura may include:

- *Call for help in the housing unit if Laura is causing disruption with the other juveniles.*
- *Document Laura's behavior and recommend an evaluation by a mental health professional.*
- *Address Laura's behavior calmly and remove her from the housing unit if necessary.*

Scenario 6 | Steven

Steven, a 14-year-old was recently arrested for a charge of burglary and is currently in juvenile detention. Since being placed on probation six months ago, he has continued to have problems adjusting to the rules and it seems his father is not able to provide him with adequate supervision. Steven's mother left the family when he was 10-years-old to get away from Steven's father, who was abusive. Steven does have a history of drug use, smoking marijuana and drinking alcohol.

Since being in detention, Steven has constantly been arguing with staff, causing disruption in the housing unit, and was seen hitting his head against the wall in his room. Steven is placed on a more secure and while doing 15 minute checks, you find Steven in his room, biting his hand, which is bleeding and crying uncontrollably.

Q: What red flags are present with Steven?

A: Steven's red flags include:

- *Previous arrest record*
- *Poor behavior in school*
- *Lack of supervision at home*
- *Self-destructive behavior*

Q: Which mental illness might Steven have?

A: Based on Steven's behavior, he may be suffering from post-traumatic stress disorder (PTSD) or major depressive disorder (MDD), but Steven needs an evaluation in order to make this determination. He may be acting out because he wants to go home or he may want to stay in detention because he is afraid of his father.

Q: What actions should be considered for Steven?

A: Some actions for Steven may include:

- *Call for help immediately, in an effort to keep Steven and other juveniles in the housing unit safe.*
- *A referral to mental health professional in juvenile detention for an evaluation or possible hospitalization.*
- *Continue frequent checks until Steven is seen by mental health professional.*

- *Document exactly what you observed in a report; information critical for the next shift and mental health professionals.*

Q: What questions do you have about the activity or the information we discussed today? *(Answer questions, if any.)*

The scenarios we discussed are hypothetical and though we talked about specific situations and ways to address a juvenile's potential mental health issues, they are nonetheless scenarios. Only mental health professionals may diagnose a juvenile's mental health issue. Our job is not to make assumptions but to observe and report behaviors we see. Further, if you suspect a juvenile may be suffering from a mental health disorder but has not been evaluated or diagnosed, you must refer the juvenile for appropriate mental health services.

Let me leave you with some final thoughts.

Slide 17 – Final Thoughts

Instructor's Corner: PG: 15

This slide appears with a title bar. Click for video to play and final thoughts to appear as they are mentioned.

Trainer Notes:

FINAL THOUGHTS

Our mental health begins to take shape early in life. Along with genetics, personal experiences shape our developing brain and its health. Disruptions in this developmental process, particularly for juveniles, include traumatic events and dysfunctional relationships with parents, caregivers, relatives, teachers, and peers. These disruptions may impair a juvenile's capacity for learning, the ability to relate with others, and may have lifelong implications.

When managing juveniles, recognizing their mental health needs is beneficial when guiding them during their supervision term. Although many of them may shy away from talking about their feelings or seeking treatment for a mental health disorder, most appreciate knowing how to cope with stressors.

Let' watch a video highlighting a juvenile who embraced therapy and learned to appreciate the process of dealing with difficult feelings.

(Click to play video titled Mental Health Treatment for Youth: It Works. Length of video is 3 minutes 33 seconds.)

Q: What do you think of the video? *(Elicit responses.)*

Like the young man in the video, many juveniles may not know resources they may access to help them deal with complex feelings or for a mental health disorder. As juvenile justice professionals, encourage juveniles to open up, provide families with strategies to cope with a mental health diagnosis, and offer structure and guidance along the way.

(Click for three final thoughts to appear.)

Some final thoughts:

- Mental health disorders affect three out of four juveniles in the juvenile justice system.
- Never make assumptions about whether a juvenile has a mental health disorder.
- Identifying prevalent mental health disorders allows us to better manage juveniles under supervision.

Thank you for attending the *Recognizing and Supervising Juveniles with Mental Health Issues* today.